AMERICAN INDIAN INFANT HEALTH INITIATIVE (AIIHI)
QUARTERLY PROGRESS REPORT

CHR/FSW complete this form every quarter.

Clinic name

Year	Quarter ending
	☐ March 31 ☐ June 30 ☐ September 30 ☐ December 31

Client/Mother (MOB) Data

MOB ID number	MOB date of birth (mm/dd/yy)

Assessments

Client/MOB New Risk Factors *(Check if any new or additional risk factors have been identified since previous encounter.)*

☐ None identified
☐ 1. Substance abuse or positive toxicity ☐ with ***OR*** ☐ without treatment (explain): _____
☐ 2. Maternal Hx of mental illness or developmental delay (parent)
☐ 3. Maternal Hx of child abuse, rape, molestation, or incest (as a victim)
☐ 4. Age <18 years or >40 years
☐ 5. Single, separated (legal or geographical), divorced
☐ 6. Self or partner unemployed or seasonal employment
☐ 7. Education <12th grade or illiterate (English or other language)
☐ 8. Inadequate income (<200% FPL or on Medi-Cal)
☐ 9. Unstable housing (homeless, frequent moves, overcrowded, multifamily)
☐ 10. No telephone or message only
☐ 11. Lack of transportation/public transport or dependent on others
☐ 12. First-time mother
☐ 13. Late (after third trimester), inadequate/sporadic, or no prenatal care
☐ 14. Hx of therapeutic abortion (actual or contemplated) or multiple miscarriages
☐ 15. Depression or suicidal ideation (past or present)
☐ 16. Child(ren) in foster home placement (past or present) or CPS involvement
☐ 17. Hx of domestic/family violence or rape/sexual assault (as a victim)
☐ 18. Other (e.g., new pregnancy, no support system/person, unplanned pregnancy, unrealistic expectation of child development) (explain): _____
☐ 19. No changes this quarter

Child(ren) Developmental Assessments *(Complete only if new assessments were made.)*

Denver Developmental Test:

☐ Normal ☐ Delayed—(Date (mm/dd/yy): _____) ☐ Not done

Ages and Stages Questionnaire (ASQ):

☐ Normal ☐ Delayed—(Date (mm/dd/yy): _____) ☐ Not done

AIIHI Workbook Developmental Assessment:

☐ Normal ☐ Delayed—(Date (mm/dd/yy): _____)

Visits

Scheduled frequency of visits:

☐ Weekly ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Other

Actual number of home visits	Number of unsuccessful home visit attempts	Number of phone counseling

If no contact was made, indicate the reason (check all that apply):

☐ Client did not want visit ☐ Could not locate client ☐ FOB/family member objected
☐ Other (explain): _____

Visits (continued)

Referrals Made in This Quarter *(Check all that apply.)* (See *Suggested Referrals and Sample Goals List.)*

	Result (Y/N/U)*	Reason for Non-Use**		Result (Y/N/U)*	Reason for Non-Use**
☐ Childbirth class			☐ Nutrition counseling		
☐ Family planning services			☐ TANF		
☐ CHDP/well-child care			☐ Medi-Cal		
☐ Parenting class			☐ WIC		
☐ Mental health counseling			☐ OB care		
☐ Family counseling			☐ CPS		
☐ Drug and alcohol counseling			☐ Immunizations		
☐ Medical (explain):			☐ Educational (explain):		
☐ Dental (explain):			☐ Other (explain):		
☐ Cultural (explain):			☐ No referral made this quarter		

* Y=Yes, client received the referred service; N=No, client did not receive the referred service; U=Unknown whether client received the referred service.

** Reasons for non-use of referred service—Choose the reason why client did not receive the service from the list below:

1. Forgot appointment
2. FOB/family members objected
3. Problem with child care
4. Problem with transportation
5. Problem with making appointment
6. Not eligible for service
7. Negative experience with previous treatment/appointment
8. Too early to assess result, referral made recently
9. Other
10. Unknown

Family Goals (Goals should relate to client's risk factors. See *Suggested Referrals and Sample Goals List.)*

☐ None established yet.

	Met	Not Met/Ongoing Progress Made	No Progress Made
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐
4. _____	☐	☐	☐

Pregnancy/Birth Data

A. Client currently pregnant
☐ Yes ☐ No

B. Client gave birth this quarter
☐ Yes ☐ No If yes, complete the following:

Type of birth
☐ Singleton ☐ Multiple

Date of birth (mm/dd/yy)

Birth weight
_____lbs._____ oz.

Gestation
☐ Preterm (-37 weeks) ☐ Full term (38–42 weeks ☐ Post term (43+ weeks)
☐ Stillbirth ☐ Spontaneous abortion ☐ Therapeutic abortion

Birth Complications (Check all that apply.)

Mother
☐ None
☐ Medical (including C-section)
☐ Drug/alcohol use-related
☐ Infections
☐ Other (explain):_____

Child
☐ None
☐ Medical
☐ Drug/alcohol exposure
☐ Developmental
☐ Other (explain): _____

C. Client has children under age 5 in home (NOT including the newborn described above
☐ Yes ☐ No

Father (FOB) Data

American Indian	Date of birth (mm/dd/yy)	Age	If DOB is unknown, enter estimated age	Involved with pregnancy/child
☐ Yes ☐ No ☐ Unknown				☐ Yes ☐ No ☐ Unknown

Conditions of Client/Family *(Choose the answer that best describes client/family **this quarter**.)*

Client's attitude toward visits:
☐ Not interested ☐ Undecided ☐ Participating ☐ Unknown/not applicable

FOB's attitude toward visits:
☐ Not interested ☐ Undecided ☐ Participating ☐ Unknown/not applicable

Other family members' attitude toward visits:
☐ Not interested ☐ Undecided ☐ Participating ☐ Unknown/not applicable

Client's condition in general:
☐ Unstable* ☐ Unstable* at times ☐ Stable ☐ Unknown/not applicable

Child(ren)'s condition in general:
☐ Unstable** ☐ Unstable** at times ☐ Stable ☐ Unknown/not applicable

Client's parenting skills:
☐ Unskilled ☐ Some skills ☐ Skilled ☐ Unknown/not applicable

Client's interactions with child(ren):
☐ No/little interaction ☐ Some interactions ☐ Good interactions ☐ Unknown/not applicable

Client's relationship with FOB/partner:
☐ Always unstable* ☐ Unstable* at times ☐ Stable ☐ Unknown/not applicable

Client status as of end of this quarter:
☐ Same as start of AIIHI or less stable ☐ Some improvements ☐ Valuable improvements attained

* Client needs additional support to cope with daily stressors.
** The home environment lacks nurturing and support for the child(ren).

Notes:

Family Education (Select the section discussed this quarter)

Guide or Workbook Section(s):

☐ Pregnancy ☐ 4–7 months ☐ 1–2 years ☐ 3–5 years
☐ 0–3 months ☐ 8 months to 1 year ☐ 2–3 years ☐ Parents' health

Case Disposition

☐ Currently in AIIHI ☐ Active ☐ Inactive (but remains in AIIHI)

☐ Dropped from AIIHI Date (mm/dd/yy): _____

Reason *(check all that apply):*

☐ Client does not want visit
☐ FOB/family member objects
☐ Child(ren) over 5 years old
☐ Client moved out of area
☐ Cannot locate client
☐ Client stable or independent
☐ Entered Head Start
☐ Other (explain): _____

Completed by:	Date last updated